



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PRESBYTERIAN HOSPITAL
3255 W. PIONEER PKWY
ARLINGTON, TX 76013

Respondent Name

STATE OFFICE OF RISK MANAGEMENT

Carrier's Austin Representative Box

Box Number 45

MFDR Tracking Number

M4-09-3747-01

MFDR Date Received

MAY 21, 2008

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Claim was not paid at all not even 'fair and reasonable' like all other Texas counties in regarding Workers' Compensation...We are asking the allowable to be 140%-over-Medicare."

Amount in Dispute: \$15,000.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Pursuant to Rule §134.01 (a)(4)(5), outpatient surgical care and emergency services shall be reimbursed at fair and reasonable rate until the issuance of a fee guideline addressing these specific types of reimbursements. ..The Office fully complied with Rule 134.1 and maintains a fair and reasonable reimbursement was made for the services in dispute based on the following methodology."

Response Submitted by: State Office of Risk Management, PO Box 13777, Austin, TX 78711

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
May 23, 2007	Outpatient Hospital Services	\$15,000.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 151-Payment adjusted/undocumented services

- 304-Submit Supply House Invoice for additional payment
- 510-Payment Determined
- B15-Procedure/Service is not paid separately
- W10-Payment based on fair & reasonable methodology
- 16-Not All Needed for Adjudication was supplied
- 50-Service not Deemed 'Medically Necessary' by payer
- 524-Recommended allowance per Insurer decision

Findings

1. The insurance carrier denied CPT code 97003 with reason code 50– “Service not Deemed ‘Medically Necessary’ by payer.” Former 28 Texas Administrative Code §133.301, effective July 15, 2000, 25 *Texas Register* 2115, states, in pertinent part, that “The insurance carrier shall not retrospectively review the medical necessity of a medical bill for treatment(s) and/or service(s) for which the health care provider has obtained preauthorization under Chapter 134 of this title (relating to Guidelines for Medical Services, Charges, and Payments).” Review of the submitted information finds that the documentation submitted by the healthcare provider does not support that preauthorization for the disputed services was obtained prior to providing services to the injured employee. The insurance carrier’s denial code is appropriate. CPT code 97003 is not eligible for medical fee dispute resolution per 28 Texas Administrative Code §133.305(a)(5) and therefore, will not be considered in this review.
2. This dispute relates to services with reimbursement subject to the provisions of Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers’ compensation health care network shall be made in accordance with subsection §134.1(d) which states that “Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available.”
3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual’s behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. 28 Texas Administrative Code §133.307(c)(2)(C), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include “the form DWC-60 table listing the specific disputed health care and charges in the form and manner prescribed by the Division.” Review of the Table of Disputed Services finds that the requestor did not list the specific disputed health care and the amounts billed for each specific service. The requestor has therefore failed to complete the required sections of the request in the form and manner prescribed under §133.307(c)(2)(C).
5. 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable.” Review of the submitted documentation finds that:
 - The Claim was not paid at all not even ‘fair and reasonable’ like all other Texas counties in regarding Workers’ Compensation...We are asking the allowable to be 140%-over-Medicare.
 - The Division has previously found that a reimbursement methodology based upon payment of a percentage of a hospital’s billed charges does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the adoption preamble to the Division’s former *Acute Care Inpatient Hospital Fee Guideline*, which states at 22 *Texas Register* 6276 that:
 “A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources.”
 Therefore, a reimbursement amount that is calculated based upon a percentage of a hospital’s billed charges cannot be favorably considered when no other data or documentation was submitted to support

that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.

- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

11/29/2012
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.